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# The General Practitioner's Role in Alcoholism

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A FEW years ago the United States Public Health Service estimated that there were 400,000 cases of tuberculosis in the United States. At the same period it was estimated by scientific statisticians that there were 4,000,000 cases of alcoholism throughout the nation. This figure, which is now on the conservative side, is mentioned only to give some idea of the immense size of the problem of alcoholism: ten times as many cases of alcoholism as there are of tuberculosis. It pervades every walk of life, both sexes, and every condition of society. The picture of the alcoholic as a skid row character is entirely misleading. Less than 10% of these four million are on skid row. The vast majority are still living at home, are still working more or less, and are still affecting the lives of the families with whom (or on whom) they live.

Physicians sometimes think of alcoholics in terms of the late chronic type, who are admitted to the wards of the big city hospital from the alleys and hovels of skid row, who are on the verge of delirium tremens, and who have little or nothing to return to on release from the hospital. This is not the average, typical picture of alcoholism as that condition is understood today. From such a false picture there can result nothing but misconceptions as to the role of the average physician in meeting the widespread medical problem of alcoholism.

Naturally, it would be presumptuous for a layman to tell physicians what is and what is not a medical problem. In writing at all about the medical aspects of alcoholism, I feel that my position is merely that of a reporter. I have been in touch with large numbers of alcoholics during the past ten years, have often worked in cooperation with their physicians, and have been in contact with the medical experts in this field both on the lecture platform and through their writings in the medical journals. This enables me, perhaps, to be of some service to the readers of LINACRE QUARTERLY by reporting to them what the experts are saying about alcoholism and about the role of the physician in this extremely widespread public health problem. And so I have accepted the invitation of the editors to contribute this article. My remarks are not addressed, therefore, to the specialist — whether psychiatric or medical — but rather to the general practitioner, and those other physicians who frequently see these cases in the course of their own practice whatever their specialty may be.

### Alcoholism as a Sickness

That alcoholism is a medical problem, at least in part, is now generally recognized. The educational work of the National Committee on Alcoholism, the Yale Center of Alcohol Studies, and of other agencies has not been without fruit. The general public has heard over and over again: 1) that the alcoholic is a sick person; 2) that the alcoholic can be helped; 3) that he is worth helping, and 4) that this is a medical and public health responsibility. More even than the general public the profession itself now stands committed to the concept of alcoholism as a sickness. For instance, the World Health Organization and the American Medical Association, to name but two influential bodies, accept that concept.

The idea has encountered some resistance, however. One reason is that it is impossible at present to identify a definite disease entity which all alcoholics have in common. Alcoholism is not like diabetes or tuberculosis or the various heart diseases in this respect. Exaggerated claims of that kind merely put obstacles in the way of acceptance of alcoholism as the sort of illness it is.

Another objection to the illness concept is raised by those who feel that this gives the alcoholic a good reason to go on drinking, and say: "I can't help it; I'm a sick man." In my own observation I have seen a few cases of this kind, but very few. It is not an excuse made by the vast majority of alcoholics who are still drinking. For the vast majority of these do not believe they are alcoholics themselves. When they read or hear about alcoholism as a sickness they invariably think it is somebody else who has the sickness. But when they finally learn that they themselves have it, they learn at the same time that it is a sickness they can do something about, a sickness that can be arrested if they will take the necessary steps to arrest it.

At all events the primary question is not whether the alcoholic will abuse the sickness concept or whether it is good tactics to tell him that he is sick. The primary question is whether it really is a sickness. The truth of the matter comes first; tactics afterwards. Actually, the sickness concept has worked better than anything else in getting alcoholics to do something about their drinking.

I believe that the medical profession in general and psychiatry in particular are the proper judges of what the label "sickness" means, and that they are the proper judges as to whether the condition alcoholism deserves that label. At present the overwhelming majority of physicians concede that alcoholism is a medical problem, and I have never come across a single medical expert in the alcohol field who is not convinced that the alcoholic is a sick person who deserves to be treated as a patient. Medical associations and medical schools are now following the lead of the American Medical Association in this respect.

Perhaps the most telling reason for looking at alcoholism as a sickness is the simple fact that an al-

coholic can never learn to drink normally, no matter how hard he tries. On this point the experts are unanimous, and it is absolutely agreed that the practical goal of treatment must be complete abstinence. After years of sobriety an alcoholic will react normally if he starts drinking again. Why is this so unless there is something wrong with him? Unless there is something inside him, physiological or psychological or both, that makes him react that way? That something, whatever it is, is rightly called pathological.

The explanations why this is so, and the whole question of etiology, leave much to be desired, as far as I can gather from the literature. Researchers in physiology have not been able to agree so far on a clear, definite, organic or functional pathology which afflicts all or most alcoholics. But some of them believe that the abnormal drinking of some alcoholics results partly from a bodily pathology, and still more believe that in many or most alcoholics, once they have become addicts, physiological changes have occurred which prevent them from ever becoming normal drinkers. On the psychological side the causation is also obscure, although psychological explanations are in the ascendancy at the present time. It is much easier, at least, to point to some psychological trait, for instance a neurotic trait, as a contributing factor to the abnormal drinking, than it is to identify a bodily pathology.

But whatever the causes, it seems clear that the psychological and/or physiological mechanisms involved in addiction deserve to be called pathological. The alcoholic, once he has become an addict, that is a compulsive drinker, has acquired a dependence on alcohol which is beyond his power to control, unaided. This addiction can often be as strong and sometimes stronger than drug addiction. He is the victim of a habit so severe and so strong that it has assumed pathological proportions.

It is precisely at this point, I think, that the most persistent resistance to the sickness concept occurs. Alcoholism involves, as a general rule, conduct and misconduct, including the excessive drinking itself, which at first sight looks to the ordinary person as though it were within the power of the drinker to control. Even the alcoholic himself goes on believing for years that he "can take it or leave it," when it is obvious to everyone else that he is incapable of drinking moderately and has lost control. And since the compulsion to drink is not absolute and uninterrupted, but takes over with more or less frequency and more or less force, the question of the alcoholic's control on a particular occasion, and the consequent degree of his moral responsibility, is never an easy one. But no one who has a wide acquaintance with these problems in the concrete believes the alcoholic merely has to use his will-power in order to stop drinking. No one believes that he inflicts the agonies of a long drinking career on himself out of sheer obduracy and willfulness. There is something wrong with him which

cannot be explained in merely moral terms.

Perhaps self-indulgence has degenerated into addiction. But once the addiction or compulsion has set in, there is a new problem. It is no longer the comparatively simple moral problem of deliberate drunkenness. It is the complex problem of alcoholism, which includes moral problems, but cannot be reduced to them. And because it is such a complex pathology, there is a growing tendency to describe alcoholism as a triple sickness, a sickness of body, of mind, and of soul.

Naturally, I would be the last to minimize the sickness of the soul. But if alcoholism is a sickness in the medical sense, too, and if more than four million Americans have it, then the average physician will see alcoholics frequently. He will be face to face with the medical responsibility involved. He will have an important medical role to play.

### The Role of the General Practitioner

What role is the general practitioner expected to play when he meets up with cases of alcoholism?

First of all it is a *cooperative role*. If alcoholism is a complicated and many-sided condition, if it involves sickness of body, mind, and soul, and if its arrest often depends also on socio-economic factors, then obviously the physician will rarely be in a position to handle the whole thing by himself. It is within his competence to treat the bodily needs of his patient, whatever they are, but he will usually have to refer the patient to other persons or other agencies for other aspects of his treatment. This referral requires a professional knowledge of available resources, and more than ordinary tact. It is not just a question of knowing the name of another doctor and giving it to the patient. More will be said about referral later.

It is the physician's task, therefore, to treat the acute alcoholic when he needs medical treatment, to treat severe hangover, to prevent delirium tremens and convulsions. When an alcoholic's condition is complicated by the so-called diseases of alcoholism, such as cirrhosis, pellagra, and all the others (as it is, they say, in about one quarter of the cases of alcoholism in the United States), the physician is naturally the one to manage this part of the problem. There is much literature on the treatment of acute alcoholism.[1]

The long range treatment of the alcoholic may also have its medical aspects. Recently developed drugs like disulfiram (Antabuse) have greatly increased the physician's resources and success in treating the chronic condition. Still more

[1]See for example: Feldman and Zucker, "Present-Day Medical Management of Alcoholism," *Journal of the American Medical Association*, 153 (Nov. 7, 1953) 895-901. Reprints of this article and further literature on treatment are available from the National Committee on Alcoholism, Suite 454, New York Academy of Medicine Building, 2 East 103 St., New York 29, N. Y. The Yale Center of Alcohol Studies, 52 Hillhouse Ave., New Haven, Conn., maintains *The Abstract Archive of the Alcohol Literature*, and can furnish information on current materials concerning treatment and other aspects of alcoholism.

recently hopes have been raised that the new tranquillizers, such as chlorpromazine (Thorazine) and meprobamate (Miltown) will prove useful. It is generally noted, however, that all these drugs are merely adjuncts in an overall program of therapy. This long range medical treatment is more often (but by no means exclusively) undertaken by physicians who are specializing in alcoholism or at least have a special interest in it.

In other words, the cooperative role of the general practitioner does not ordinarily include the long term therapy of the alcoholic. Everyone is well aware (except, in many cases, the alcoholic himself) that recovery from an acute episode is only the beginning of the battle, and that eventual permanent recovery requires a great deal more. But perhaps it happens too often that a false idea of the long range prospect is engendered in the mind of the patient when he hears from his physician: "Now I've got you well again; the rest is *up to you.*" Or "I can sober you up; but staying sober *is your own job.*" Or "Now you're *on your own.*" Very few alcoholics ever recover on their own. The vast majority need continued help, though often enough it is not continued medical help. Perhaps it is spiritual, perhaps it is psychiatric, perhaps it is social. Often it is all of these.

The program of Alcoholics Anonymous has been more successful in the permanent contented recovery of large numbers of alcoholics than anything else about which we know. It offers help to alcoholics that they cannot get anywhere else. It does not cost anything and it works. It is a mistake for the physician to give his patient the impression that his long range recovery is up to himself, as though he can remain sober merely by deciding to, and by exercising his will-power. It is not ordinarily the practitioner's job to conduct long range therapy himself, but he must be forthright in making it clear to the patient that he is suffering from a progressive and insidious disease, and that he needs continued outside help. The physician must be skillful in indicating where he can get it. A.A. is one of his best resources.

This brings us to what, in my opinion, is by far the most important contribution the average physician can make. *When he encounters the alcoholic, he can diagnose his alcoholism.* But to do it he requires: 1) the knowledge to make a diagnosis of alcoholism, and 2) the courage and tact to communicate the diagnosis tellingly to the patient. Since this is a cardinal point in the whole cooperative effort to do something about alcoholism, let us explore these ideas a little further. Diagnosis is a key factor.

### Knowledge to Make the Diagnosis

Frequent complaints are heard among workers in the field that many doctors are not well-informed about alcoholism. In fact, they say it is often hard to find a non-specialist to whom they feel safe in referring the alcoholic patient for the medical part of his

treatment. They are afraid the physician may just sober him up, "give him a good talking to," and tell him he is on his own. Or tell him to "drink like a gentleman," or "drink only beer," or "use your will-power and stop after two drinks." Or he may prescribe barbiturates for the hangover period without realizing the special precautions that are imperative when giving alcoholics any sedation. Barbiturate addiction is a distressingly frequent complication among alcoholics today.

Or the doctor may even tell the patient he "is not an alcoholic," meaning by that, perhaps, that he is not a chronic alcoholic in the medical sense, which formerly limited that term to one whose excessive drinking had reached the point where it was complicated by one or more of the so-called diseases of alcoholism. The prevailing usage today, adopted internationally by the World Health Organization expert committee on alcoholism, and by most specialists in the field, gives a much broader meaning to the term "alcoholic." It is estimated that in the United States only one in four alcoholics has one of the complicating diseases. It is this equivocation in terminology that leads to many misunderstandings.

But whether such complaints are justified or not, it remains true that physicians, like educators, clergymen and everyone else, including the experts, still have a lot to learn about alcoholism. The medical schools recognize this and are beginning to give specific attention to this subject in their curricula. Professional scientific journals and county medical societies more and more frequently discuss the problem for their readers and their members. An organization like the National Committee on Alcoholism stands ready to supply members of the medical profession with a limited amount of up-to-date literature, and to recommend pertinent materials. Physicians are gradually being put in possession of the information they need in order to make a diagnosis of alcoholism.

Actually, is it such a difficult thing to do? It is, if the diagnosis is going to be made on the basis of some theory as to the causation of the condition. As already mentioned, the etiology is obscure. No one has isolated a psysiological entity or a psychological trait which *is* alcoholism.

But it is not difficult merely to describe the alcoholic in terms that distinguish him, for practical purposes, from other excessive drinkers who are not alcoholics. This is the fundamental thing, both for the purpose of clinical classification, and for the purpose of long range therapy. Several such descriptions are available. The one I suggest here fairly describes and distinguishes the vast majority of those persons who are called alcoholics nowadays by physicians, psychiatrists, lay therapists, specialists, A.A.'s and others working in the field. The alcoholic has these three traits: 1) *Excess.* He has been drinking excessively over a period of years. 2) *Problems.* He has serious life problems caused by or connected with his excessive

drinking. 3) *Compulsion.* He does not stop drinking completely even when he wants to and tries to, unless he gets outside help. When he tries to drink moderately he fails in spite of sincere efforts to stay within the bounds of moderation.

Excess is a matter of degree. Some alcoholics get completely drunk only rarely, but they do get thoroughly and frequently tight. Some get drunk on rather small amounts, some on large quantities. The reason why the "period of years" is mentioned is that sometimes wild drinking over shorter periods turns out to be merely a passing phase, and such drinkers settle down and learn how to drink moderately. Hence, it may be difficult to be sure of a diagnosis of alcoholism except on the basis of a somewhat extended drinking history. Naturally, it is highly desirable that alcoholism be recognized as early as possible. But even if it could be recognized from the first drink (or before) it would probably be pretty hard to convince a patient that he had alcoholism except on the basis of his own continued, abnormal drinking behavior.

Problems are a matter of degree, too. They range all the way from a serious disruption of family harmony, through loss of job, or of health, loss of moral ideals, loss of faith, of self-respect, commitment to jails and institutions, etc., all the way down to skid row. It is very important for the physician to recognize that there are many, many alcoholics who have not yet seriously injured their health, or social position, and who are very far indeed from skid row.

It is true that experienced A.A.'s (those retired champions of the drinking world) believe that a man has to hit bottom before he will get better. But they distinguish high bottom and low bottom, and some even speak of seeing bottom instead of hitting it. For one individual "hitting bottom" may be a single, deep emotional experience; for another, a spiritual experience. It is a highly relative concept. In any case, it is not hitting bottom that makes a man an alcoholic, it is hitting some kind of bottom that makes him realize it. They are diagnosable as alcoholics long before that happens, and the doctor plays his role by helping them to realize it.

Compulsion, most of all, is a matter of degree. It operates with more or less frequency and more or less force. It is a kind of fascinated thinking about alcohol or about the next drink, which takes possession of the alcoholic's mind on certain occasions, constrains him to drink even against his better judgment and his sincere determination not to. An alcoholic cannot safely take one drink. Not even of beer or of wine. It is even dangerous to prescribe medicine for him, such as cough syrups or elixirs, which have an alcoholic content. It is often after a drink or two that his compulsion is touched off and he is overwhelmed by an addictive urge to drink more.

This is not the place to discuss the moral implications of compulsive behavior, and I am far from intending that, just because one

alternative is more attractive or alluring than another, one is compelled to choose it. Human emotion, passion and concupiscence, the attraction of the sense appetites, cause conflicts in all of us. That is not sickness, unless it is the sickness of original sin. But I am speaking of a type of compulsive thinking which has reached pathological proportions, a kind of fascination with one alternative which precludes a truly realistic appraisal of the other. When this happens, the moral responsibility for the act that results is greatly diminished and sometimes eliminated.[2]

The reason why it is impractical to talk to the alcoholic about using his will-power is that his sickness consists precisely in this: he has no will-power with regard to the object of his compulsion at those times when the compulsion takes over. People do not escape the domination of a compulsion or an addiction by saying, "I won't, I won't, I won't." And we give them very poor assistance when we keep saying, "Don't, Don't, Don't." Compulsions cannot be directly overcome by will-power. They have to be forestalled or circumvented.

The test of this compulsion is not the ability to stay away from alcohol completely for a week, or a month, or a year. So often the inexperienced will say: "He is not an alcoholic. He didn't touch a drop all during Lent, and there was plenty around." The test of alcoholism is not abstinence. Thousands of recovered alcoholics never touch a drop, but they are still alcoholics, because if they drank again, they would soon be in trouble again. The test is the ability to drink regularly with true moderation. A person who can do that is not an alcoholic. If there is one thing that all the experts are unanimously agreed upon it is this: an alcoholic can never learn to drink moderately. In fact, some would make this the definition of an alcoholic and the criterion of alcoholism: — "a person who cannot learn to drink moderately no matter how hard he tries." And they would not be far wrong.

When these three are present together — excess, life problems, and compulsion — the physician need have little doubt that he is dealing with an alcoholic. It does not take a specialist to make this kind of a diagnosis. But it requires familiarity with the patient's drinking history, and familiarity with the characteristic patterns of alcoholic drinking, *i.e.*, the characteristic phases of alcoholism. The first of these, the history, can be obtained at least in part from the patient himself. The history referred to here is not a psychiatric history, looking to the underlying psychological causes of the abnormal drinking, but enough of his drinking history to divulge the tell-tale pattern of alcoholism. Perhaps this tell-tale pattern is thrice apparent without any history taking at all. One of the advantages of the general practitioner is that he often knows the family and personal his-

[2]See *Depth Psychology, Morality and Alcoholism*, John C. Ford, S.J., Weston College Press (Weston 93, Mass.), 1951, pp. 66-76.

tory of the patient. But at least the history taking will impress the patient with the fact that when the diagnosis is made, it is made on the basis of thorough knowledge. Perhaps the time will come when some ingenious expert will devise the key questions to be asked and will put them out in convenient form for the physician's use. Frequently, however, the wife or husband or members of the patient's family are needed to supplement the patient's own account of his drinking. For if he is an alcoholic, he may have little insight, and may deceive the physician with or without deliberate intent, in important matters.

As for the second point, the characteristic phases of alcoholism have been very usefully described by Jellinek.[3] There are various more popular diagnostic aids such as the twenty question test, the thirteen steps to alcoholism, the characteristic behaviors of alcoholism, etc., which may be of help to both doctor and patient in making the diagnosis.[4]

Doctors may ask why the experts have adopted the broader definition of alcoholism and relinquished the older medical one based on the complicating diseases. The reasons are practical. First, the broader conception is now very widely accepted nationally and internationally. Uniformity of terminology is desirable. Secondly, for purposes of diagnosis and referral for long range therapy, whether the referral is to a psychiatric specialist, a medical specialist, a spiritual guide, or A.A., the crucial point is not the presence or absence of a complicating disease. The crucial point is: can this person ever learn to drink normally again? If it is judged that he cannot, then no matter where he is referred, no matter to what school of thought the specialist belongs, the practical goal of treatment will be the same: *complete abstinence for life.* No one believes that there is any hope in the present state of our knowledge, of teaching alcoholics how to drink moderately. It is agreed, of course, that most alcoholics will have to make thorough-going psychological readjustments in order to come to terms with life, and that they may need psychiatric help to do it. But even those who shrug off the drinking itself as a mere symptom of the alcoholic's underlying mental or emotional illness, and try to treat that underlying cause, can never call their treatment successful until they get rid of the symptom.

Compulsive drinking, if a symptom, is a runaway symptom, which acquires an importance of its own. People die of it. From one point of view suicide also is just a symptom of an underlying mental illness. But unless you control this symptom you have a dead patient on your hands.

One of the foremost psychiatric

[3]E. M. Jellinek, *Phases in the Drinking History of Alcoholics,* Hillhouse Press, New Haven, 1946.

[4]See for example the literature provided by local information centers on alcoholism, by State sponsored programs, etc. The characteristic behaviors of alcoholism are also listed in: *Man Takes a Drink,* John C. Ford, S.J., Kenedy, New York, 1955, at pp. 90-96. For the twenty question test see *Depth Psychology, Morality and Alcoholism,* p. 49, note 116.

experts in alcoholism, Dr. Harry M. Tiebout, in a frank talk to his colleagues, declares that the reason why the psychiatrist fails so often in the treatment of alcoholics is that "he bypasses the disease and looks for causes; he ends up talking about earlier experiences and never gets close to the patient or the illness." And he states further: "Any treatment of the alcoholic must be remedial. There is no present value in getting at the causes and correcting them because the net result of such an endeavor would be to enable the person to drink normally. While such a goal may be achieved in some far-off millenium, its attainment in the immediate future is absolutely unlikely. Any therapy devoted to such a goal is admittedly unrealistic; everyone acknowledges that there is no present cure, that the only remedy is total sobriety. The person does not learn how to handle liquor, he stops using it. The goal of therapy, therefore, is to get the patient to stop taking the first drink."[5]

### Courage and Tact to Communicate the Diagnosis Tellingly

Alcoholism understood in this light is a diagnosable disease, and easily diagnosable — except by the alcoholic himself. He generally does not know what alcoholism is. He cannot think of himself as an alcoholic. He cannot bring himself to believe he is one. The general practitioner or family physician is ideally situated to do a good educational job. He is on the firing line. He often knows the family and personal history. He may be the first one to see the case, and his attitude is going to make a lasting impression on the patient. Americans listen to their doctors and respect their opinions in medical matters.

I do not mean that the alcoholic will recognize himself as such the moment the doctor tells him, much less that he will immediately stop drinking. It may take time and repetition and more bouts with the bottle before he will be ready to let the idea take hold. But it is an essential part of his education about his own disease that he be told about it by a medical man who shows that he knows what he is talking about. It is essential that he be told in no uncertain terms: "You have alcoholism," or "You have developed alcoholism." (And these phrases, by the way, seem to be more effective and more acceptable than "You are an alcoholic.") It is not easy to break this hateful news. For the physician to communicate this diagnosis tellingly, he needs both courage and tact.

If the doctor has not the courage of his convictions, the patient will sense it very quickly. If he accepts alcoholism intellectually as an illness, but does not accept the alcoholic emotionally as a sick man; if he is not deeply and personally convinced that alcoholism is truly a medical problem; if he still harbors the idea that alcoholism may be an illness but it is not a "legitimate" illness; if he sets himself up as a judge and implies by

[5]Excerpts from a paper presented to the National States Conference on Alcoholism in October, 1955, reprinted in *The A.A. Grapevine*, 13 (Sept., 1956), pp. 5-10.

his attitude: "You have an illness, but you brought it on yourself, and you deserve to do a little penance for it;" if he still thinks that though it is an illness, it is not his problem and that the situation is pretty hopeless anyway — these judgmental and defeatist attitudes will betray him and destroy his effectiveness with his patient.

A well-balanced attitude on drinking, drunkenness and alcoholism is a prerequisite if one is to give effective advice and treatment. I have noticed that priests and ministers who drink themselves sometimes feel uncomfortable, for no good reason, about dealing professionally with alcohol problems. There seems to be some vague feeling that they have disqualified themselves. Of course, if their personal use is somewhat immoderate, that is understandable as a defensive reaction. Something similar is observable at times in the case of a physician. If he drinks a little too much himself, he feels guilty and uncomfortable in dealing with these patients. If he has an unsolved drinking problem of his own, he may be very slow to make a diagnosis of alcoholism in his patient. He would be condemning himself. And in any event, the attitudes of our society are so confused and ambivalent where alcohol is concerned that it takes study and effort for anyone to acquire a well-informed, well-balanced attitude. But such an attitude is necessary for one who must have the courage to break the unpleasant news to the patient: "You have developed alcoholism."

It is not enough to be courageous. Tact is also necessary. A man's drinking habits are a peculiarly personal thing. One who has trouble with his drinking will consider this part of his life as much his own business as his sex life. If the physician is going to convince the patient he has alcoholism, he may have to prepare him for the news. The ideal is to lead the patient to diagnose himself as an alcoholic. There is a good deal of literature available now to help the alcoholic to do this. The physician may know very quickly what is wrong with the patient. He is just another alcoholic. But it may take more than one interview, and the passage of time, and some serious reading and study on the part of the patient, before the moment arrives for that straightforward pronouncement: "You have developed alcoholism. It is a progressive and incurable disease. It can be arrested only by complete abstinence. In order to arrest it, you will need continued help."

### Resources and Referrals

There are a good many resources available to the general practitioner who wishes to refer a patient for further help. The best of these for the majority of patients, and the most universally available, is Alcoholics Anonymous, as mentioned previously. The physician should know this program and should be personally acquainted with some successful members of A.A., so that when a patient is willing to accept help from them, the doctor will not merely "send him to A.A." but will

contact the right people in A.A. to help this particular patient.

There are thousands of A.A. groups throughout the country, at least one in every sizable town. They are usually listed in the telephone directory. If not, the address of the nearest group can be obtained from their national headquarters.[6] If there is no time for that, a telephone call to the local police station will usually elicit the desired information. Members of A.A. are ready to help *if the alcoholic himself* is asking for their help.

Many patients will not hear of going to A.A. when it is first proposed to them. Either they are still unconvinced and are determined to learn how to drink without getting into trouble, or, if they have reached the point where they admit they have alcoholism and can never drink again, they think they can manage this business of sobriety by themselves. Often one can but let them try it; but the door should be left open for a future change of mind and heart.

I do not mean to give the impression that A.A. is the only thing there is, or that for every alcoholic it is the best solution. Some alcoholics are badly in need of specialized psychiatric care, or the care of a medical specialist in alcoholism. But this is not true of the majority. The majority, besides, are in no position to pay for such care. It is easier, however, to get some patients to go to a psychiatric or medical specialist than to go to A.A. The general practitioner will know, of course, or be able to find out the right specialist in alcoholism for his patient.

One of the difficulties that plagues both specialists and generalists is the refusal of most general hospitals to admit acute alcoholics for treatment. Feldman and Zucker have this to say: "The ideal place for treatment of the acutely alcoholic patient is the hospital, and every effort should be made to convince both the patient and the hospital of the wisdom of this arrangement. It is surprising how little difficulty most acutely alcoholic patients cause in hospitals, a fact repeatedly confirmed by those hospitals courageous enough to admit this type of patient on the same basis as any other. It seems as though merely treating these people as any other sick person somehow makes them more tractable and cooperative. Occasionally they become model patients. Hospitalization in open or general hospitals is not to be recommended if the patient is actively against any treatment or if force must be used."[7]

Some general hospitals have followed the lead of St. Thomas Hospital, in Akron, Ohio, where Sister Ignatia first introduced the plan, and have instituted a five-day program of treatment in conjunction with Alcoholics Anonymous. They have had remarkable success in these institutions and have not found the alcoholic patients more difficult to handle than other types of patients they receive.

[6]Alcoholics Anonymous, P. O. Box 459, Grand Central Annex, New York 17, N. Y.

[7]*Loc. cit.*, p. 896.

The families of alcoholics have put up with so much that they are often thoroughly disorganized, and it is often the wife of the alcoholic who seeks the physician's help. The Al-Anon Family Groups, Inc. — an offshot of A.A. but not directly connected with it — was formed to help the families, especially the wives, of alcoholics to meet their problem wisely and effectively. There are now hundreds of these groups throughout the country.[8]

If alcoholism is a sickness of body, mind, and soul, many alcoholics, if not all of them, need spiritual help. There are cases where the doctor can help them to get it. The physician who, in accordance with the highest ideals of the profession, considers himself not merely a scientist and technician but a healer, with the total welfare of his patient at heart, can often put a confused alcoholic on the right track. This is especially true if there are clergymen available (and the number is steadily growing) who have an understanding of alcohol problems and take a special interest in them.

The general practitioner can also make good use of the services offered by the National Committee on Alcoholism.[9] This is the national clearing house for information on developments and activities in the field of alcoholism. It disseminates the latest scientific findings in this field, and also guides and stimulates the establishment of community programs on alcoholism. Literature is available, including literature for physicians, from the national headquarters. The Committee has about fifty local affiliated committees, operating programs of information, organization, education and guidance. Some of them are in a position to guide the individual alcoholic, through experienced counsellors, to the help best suited to him. They can also inform the doctor of all the local treatment facilities for handling alcoholics.

One of the most encouraging developments from the medical point of view is the establishment of State programs to deal with alcoholism. There is a great variety and number of such programs throughout the United States. Some of them operate special hospitals and out-patient clinics with a staff trained to carry on the long range therapy of the alcoholic. Information about a State program, if there is one, and about all the local treatment facilities for alcoholics, can be obtained by contacting the State Health Department.

Finally, many of the local medical societies have now organized special committees on alcoholism. These committees know the local resources and will guide the physician in referring his patients to the best sources of continuing help.

In writing the above observations on the role of the general practitioner in alcoholism, I have

[8]The Al-Anon Family Groups, Inc., P. O. Box 1475, Grand Central Annex New York 17, N. Y. A very useful book for the family of the alcoholic is: *Primer on Alcoholism,* Marty Mann, Rinehart and Co., New York, 1950.

[9]The National Committee on Alcoholism, Suite 454, New York Academy of Medicine Building, 2 E. 103 St., New York 29, N. Y.

said very little about the moral, spiritual, and religious aspect of these problems. This is not because I underestimate them. In the last analysis, the excessive drinking of alcohol is a problem of human behavior. Like every such problem, it has theological implications, illustrating vividly the mysterious interplay of free will and divine grace within the human soul. The grace of God is all-important to the alcoholic. The physician by his skill, his understanding, his tact and his compassion can remove the obstacles to that grace. He can be compassionate without being mawkish. He can be tactful without pussyfooting. He can be forthright without crushing.

But if alcoholism is a triple sickness, it has its medical side, and the general practitioner has a cooperative medical role to play. If he knows the facts about alcoholism, if he has the knowledge, the courage and the tact to make a forthright diagnosis, if he knows the available resources, he can guide these patients to recovery. Recovery means contented sobriety. The situation is no longer hopeless. The recoveries will soon be numbered in hundreds of thousands.

Readers will be glad to know that Father John C. Ford, S.J., was named this year's recipient of the Cardinal Spellman Award, for outstanding achievement in the field of sacred theology. In addition to his doctorate in sacred theology, Father Ford has received the degree of bachelor of laws. He has taught jurisprudence and domestic relations and is an annual guest lecturer at the Yale School of Alcohol Studies. He has been a member of the Governor's Commission on Alcoholism in Massachusetts. His writings and lectures, besides covering moral problems of alcoholism, have been concerned with the morality of obliteration bombing, and other moral, medico-moral and legal problems.

THE LINACRE QUARTERLY congratulates Father Ford on receiving this notable Award, with the wish that his work will continue with God's choicest blessings.

## FEDERATION EXECUTIVE BOARD MEETING SCHEDULED

The Executive Board of the Federation of Catholic Physicians' Guilds will meet Dec. 8-9, 1956, beginning at 9:30 a.m., Hotel Statler, Cleveland, Ohio.

The officers of the Federation and one delegate from each active constituent Guild constituting the Board will conduct business.

# POPE PIUS XII

## to the

# GUILD OF ST. LUKE

*EDITOR'S NOTE: The address of Pope Pius XII, given November 12, 1944, to the Italian Guild of St. Luke, was perhaps the most comprehensive of all of his talks on medical morality. Moreover, it seems to have been the first of his many discourses to the medical profession; and it contained in germ many of the subsequent and very important addresses. We believe that all Catholic doctors should be familiar with its content: hence, we are presenting here a very complete digest of the Pope's words. This has been made possible through the generous cooperation of Daniel T. Costello, S.J.; Mario Jaccarini, S.J.; and Richard J. McPartlin, S.J.*

IN THE heavy atmosphere of an education at once intellectual and materialistic, an association such as yours helps to circulate a stream of fresh and healthy air. For it directs men's minds toward the fundamental truths of right reason and of faith — truths by which the great questions of medical morality are solved; it affirms Christian principles and applies them to the practical exercise of medicine as well as to the formation of young students.

### Basic Principles

Medicine and surgery use many sciences in their protection of the fragile but perfect human body: anatomy, which manifests so well the power of the Creator; physiology, which explores the functions of that wonderful organism; biology, which searches out the laws of life itself. But more than any of these, medicine is concerned with man in the totality of his relationships to society and to God.

Man, a creature of matter and spirit, is part of the ordered universe; but his destiny lies outside of time; his destiny transcends nature. In him, matter and spirit unite into a most perfect unity — that of the human composite. And because this composite is part of the visible world, the physician must frequently give advice, make decisions, and explain principles, which affect the soul and its faculties, man's supernatural destiny, and his social purpose — although he is directly concerned in all these with the care of the body, its members and functions.

Should he forget, even temporarily, man's dual nature — that man has not only a place and a function within the order of the universe but also a spiritual and supernatural destiny — the physician may well entangle himself in more or less materialistic prejudices; he may allow the fatal conclusions of utilitarianism or hedon-

ism to guide him; he may find himself acting in absolute independence of the moral law.

His dual nature, composed at once of matter and spirit, and the order of the universe he inhabits are so complex that man cannot fully achieve his unique destiny, cannot fully realize his personality, unless the action of his various faculties, corporal and spiritual, is harmonious. Moreover, he can occupy his rightful place in the world neither by isolating himself from it nor by completely merging himself in it, as myriads of identical molecules merge themselves in one formless mass. It is difficult to achieve the necessary harmony within the complex reality; but it is here that the physician's duty lies.

God, the Creator, has given its proper function to each of the body's organs. He has made certain of these organs essential to life; others He has designed as integral parts. To each, He has given its proper use. Man cannot, therefore, regulate his life and his organic function by his own good pleasure. He cannot ignore the internal and unchanging finality of an organ. Man is not the owner, the absolute master, of his body; he is only its administrator. From this truth flow the principles and rules which govern the licit use and disposition of the organs and members of the human body — principles and rules which apply equally to the patient and physician.

When different interests conflict, the same rules must be applied, with due regard for the commandments of God and differing values involved. Hence, it is never allowable to sacrifice eternal for temporal goods, even the greatest temporal goods. But neither is it allowable to put the vulgar, blind vehemence of passion before true temporal good. These conflicting tendencies can cause crises, sometimes tragic ones. In such circumstance, the physician may find himself rather often cast in the role of counselor, and even in that of judge.

If inevitably conflicting tendencies, albeit confined to the complex unity of the person, can cause very delicate problems, how formidable are those created by society's claims on the body, on its integrity, on human life itself! It is not always easy to settle these claims in theory; but, in practice, the physician and each one directly concerned must often examine and analyze the demands and their circumstances. They must measure and weigh their morality and the binding-force of the obligation in question.

Reason and faith delimit the respective rights of society and the individual. Undoubtedly, nature intended that man should live in society; but even unaided reason declares that society was made for man, not man for society. Man's right over his body and over his life he receives from his Creator, not from society; and it is to his Creator that he will answer for the use he makes of that right. Society, therefore, cannot directly deprive him of this right unless he has committed a crime which merits such punishment.

The juridical relation of society to the body, life, and corporal integrity of the individual is essentially different from that of the individual himself. Although it is limited, man's power over his members and organs is a direct power; for these members and organs are constitutive parts of his physical being. Obviously, as individual parts united into the perfect unity of the physical organism, their only purpose is to contribute to the good of the whole. Consequently, any of them may be sacrificed if it creates a danger for the whole that cannot be otherwise avoided. However, the nature of society is altogether different. Its members, taken collectively, do not constitute a physical body. Society is a union that arises from many individuals working in common toward a common purpose; it is a unity merely of purpose and action. Accordingly, it can exact of its members all those services which the true common good requires.

When public authority would allow or demand some procedure or interference which regards the human body, the life and integrity of the person, these are the norms by which such procedures and interferences must be judged.

### Suffering and Death

Reason alone can carry us thus far. But the law of suffering and death, more familiar to the doctor than to others, can be fully explained only in the light of revelation.

Of course, physical suffering, in one of its functions, safeguards health. It is a danger-signal revealing the existence of hidden, and often insidious, illness. Under its spur, the patient seeks relief and remedy. But sooner or later in the course of his studies, the doctor must acknowledge in death and suffering a problem he cannot solve. In his professional work, he will encounter them as an inescapable and mysterious law against which his healing art is frequently powerless and his compassion fruitless.

In diagnosis, he relies on experimental and clinical data; he makes his prognosis scientifically; but within himself he knows that the answer to this enigma persists in escaping him. He suffers because of it; and he will continue to suffer the torture of unrelenting anguish until he comes to faith for an answer. Even then, the mysterious designs of God permit only an incomplete answer. The full explanation must await eternity. Still, incomplete as it is, the answer of faith can bring quiet to the soul.

At his creation, the grace of God freely exempted man from that law of nature that binds all material, sensible being. Sorrow and death had no place in God's design. Sin put them there. But God, the all-compassionate Father, has taken them up into His hands; He made them pass through the body, the veins, the heart of His well-beloved Son — of that Son who, having the same divine nature as the Father, became man that he might become the savior of the world. For everyone who does not reject Christ, suffering and death have become the means of

redemption and sanctification. During the whole length of its history, the sign of the cross, the law of suffering and death, have dominated the course of the human race. In that course, the soul is purified and perfected and finally brought to the boundless happiness of a life without end.

Suffering and death: here is the "foolishness of God" — to use the bold expression of the Apostle of the Gentiles — a foolishness wiser than all the wisdom of men. (Cor. 1:21ff.) Even the weak light of feeble faith was enough for the poor poet to sing:

Man's a student and sorrow's his master,
'Til one has suffered, his self-knowledge is nought.
Alfred de Musset,
*La nuit d'octobre.*

The light of revelation enabled the pious author of *The Imitation of Christ* to write that sublime twelfth chapter of the second book: "On the Royal Road of the Holy Cross." Here shine forth a most wonderful understanding and a view of life of the deepest Christian wisdom.

Granted, then, this overmastering problem of suffering, what answer can the doctor give — to himself, to the unfortunate whom sickness strikes down into a gloomy torpor or who rises up in fruitless rebellion against suffering and death? Only a heart penetrated with a living and deep faith will know how to speak with the sincerity and conviction capable of bringing one to accept the answer of the Divine Master Himself: "It is necessary to suffer and to die and thus to enter into glory" (Luke, 24: 26, 46). He will have recourse to every procedure that science can supply or skill devise; but he will struggle against sickness and death with calm serenity, not with the resignation born of discouraged pessimism, and not with the frantic resolution that certain modern philosophers believe so praiseworthy. His struggle is the struggle of one who sees and knows what part suffering and death play in the salutary designs of an all-knowing, all-good, and all-merciful Savior.

### Christian Medicine

Evidently, therefore, the doctor — his person and all that he does — works continually within the limits of the moral order and under the sway of its laws. Whatever the diagnosis, whatever the advice, whatever the prescription, whatever the procedure, the doctor is never outside the domain of morality; he is never free, never independent, of the fundamental principles of ethics and religion. There is no word or action of his for which he will not be held responsible before God and his own conscience.

It is true that some reject, theoretically and practically, the notion of "Christian medicine" as an absurdity. In their view, there can no more be a Christian medicine than there can be a Christian physics or a Christian chemistry. The field of religion and ethics, they say, is distinct from that of the exact, experimental sciences.

Hence, these latter can know and recognize only the laws of their own science. What a strange and unjustifiably narrow way of envisioning the problem! Do not these men see that the objects of science are not isolated in a void, that they are a part of the whole world of diversified being? Do they not see that, within the hierarchy of being and value, each has its determined place? Do they not realize that the objects of every science are in perpetual contact with the object of all sciences and, in particular, that all are subordinate to the law of perpetual and transcendent finality that links them together in an ordered whole?

We admit, however, that when speaking of the Christian orientation of science, one must keep in mind the science, not only in itself, but also in its devotees through whom it lives, grows, and is made known. Even physics and chemistry, which scientists and conscientious professional men employ to the advantage of the individual and society, can become, in the hands of perverted men, instruments of corruption and ruin. All the more reason, therefore, for insisting that medicine be kept in its place within the general order — a place guaranteed to it by the ties of multiple relation to component parts of the system. At the present time, some pretend to an objective or subjective freedom from these ties. It is plain that, here especially, the sovereign demands of truth and goodness are opposed to any such pretension.

### Principles in Teaching and Practice

Faithful adherence to the teaching of the Church begets a profound knowledge and understanding of the truths that guide medical studies and medical activity. Moreover, it helps the individual to solve, in conformity with the moral law, the difficult cases that arise in practice. It would be impossible in a brief discourse to discuss each of these; yet we wish, for the benefit of doctors, to recall a few of the obligations imposed by the Ten Commandments.

Love is the greatest of all the commandments, love of God and its derivative, love of neighbor. True love — love enlightened by reason and faith — does not blind us; it makes most farseeing men of us. The Catholic doctor can find no better counselor in forming his judgments, in undertaking and prospering his cure of the sick. "Love, and do as you will!" This thought of St. Augustine — a concise maxim often cited out of context — finds its full and legitimate application here. What a reward it will be for the conscientious doctor to hear, on the day of eternal reward, the thanks of Our Lord: "I was sick and you visited me." Such love is not weak. It does not lend itself to make diagnoses just to please others. It is deaf to the voices of passion which would win its cooperation. It is full of goodness, without self-seeking, without anger; it does not rejoice in injustice. It believes all things; it hopes all things; it endures all things. Thus the Apostle of the Gentiles describes Christian charity in his

wonderful hymn of love (I Cor. 13-4-7).

### Inviolability of Human Life

The fifth commandment, "Thou shalt not kill," synthesizes man's duties toward the life and integrity of the human body. It is a font of knowledge for the professor in his chair and the doctor in practice. The life of an innocent man is inviolable. Any act, therefore, which seeks to destroy this life directly is illicit, whether the destruction is an end in itself or a means to an end; whether there is question of embryonic life, or life in its full bloom, or life drawing to its close. God alone is master of the life of any man who is not guilty of a crime which demands the death penalty. The doctor has no right to dispose of the infant's life or of the mother's life; and no one in the world, no private person, no human power can authorize the direct destruction of either life. His task is not to destroy but to save. These are basic, unchanging principles which the Church has been forced to vindicate against error many times in recent decades. In them and in the teaching Church, the Catholic doctor finds a sure and certain guide in thought and practice.

There is another large area in the field of morals which requires of the doctor an especially clear understanding of principles and surety in action: that in which a mysterious power implanted by God in the organism of man and woman procreates new life. This power is a natural one. Its structure, the essential forms of its activity, have been determined by the Creator Himself. It has a primary purpose: the procreation and education of children; it has corresponding duties — duties which bind man in his voluntary use of this faculty. Marriage alone, regulated by God Himself in its essence and in its properties, realizes this purpose in accordance with the dignity and well-being of the child and of the parents. This rule alone determines the whole delicate matter with clarity. It is a norm to which we must conform ourselves in all concrete cases, in all particular questions. It is a norm, finally, whose faithful observance guarantees the moral and physical health of each individual and of society.

To understand, to accept, and to make practical applications of this imminent finality lying deep in nature itself should not be hard for the doctor. And when he warns that whoever transgresses these laws of nature must sooner or later suffer the fatal consequences to personal dignity, to physical and psychic integrity, people will credit him more readily than the theologian.

Consider a young man who has recourse to a doctor under the influence of unfolding passion. Take the engaged couple who seek his advice on the eve of marriage — often enough, unfortunately, in a spirit at odds with nature and virtue. Think of the married who come in search of enlightenment and help or, more often, of connivance. The wilful violation of the obligations inherent in the use of marriage is the only solution,

the only way to safety, so they say, in the hard battle of life. They will use every argument, every possible excuse (medical, eugenic, social, moral) to make the doctor give them advice or assistance which will permit the satisfaction of the natural appetite while making it impossible for the appetite to realize its purpose: the generation of life. How shall the doctor stand firm before these assaults? How indeed, unless he has a clear understanding and a personal conviction that the Creator Himself, for the good of the human race, has linked the voluntary use of the sexual faculty to its intrinsic end by an indissoluble bond that admits neither of relaxation nor violation.

### Telling the Truth

The eighth commandment has an equally important place in medical morality. The moral law never permits a lie. Nevertheless, there are cases in which a doctor may not cruelly speak the whole truth, even if asked; especially when he knows the sick person does not have the strength to bear it. However, there are other cases in which there is an undoubted duty to speak clearly — a duty before which all other considerations, medical or humanitarian, must give way. Thus, it is never permissible to lull the patient or his relatives into a sense of false security with risk to his eternal salvation or to the fulfillment of obligations of justice or charity. It would be a mistake to justify or to indulge in such action on the plea that a doctor always expresses himself in the way he thinks best for his patient and that it is the fault of others if they take his words too literally.

### Professional Secrecy

Among the duties that flow from the eighth commandment, the obligation of professional secrecy must also be mentioned. It safeguards the individual and, even more, the common good. Here too, conflicts can arise between private and public good, or between various aspects of the public good. It will be extremely difficult at times to measure and weigh equitably the reasons for speaking and for keeping silence. In doubts of this kind, the conscientious doctor will seek in the fundamental principles of Christian ethics rules which help to guide him correctly. These rules, while affirming clearly the obligation of keeping the professional secret — especially in the interest of the common good, do not have an absolute binding-force. The common good itself would forbid professional secrecy to be put at the service of crime or fraud.

### Scientific Formation and Development

Finally, We would not omit a word on the doctor's obligation to possess a solid scientific training. But training alone is not enough; he must continually develop and cultivate his knowledge and his professional skill. There is question here of a moral obligation in the strict sense, of an obligation which binds in conscience before God, since it deals with an activity which intimately concerns the es-

sential goods of the individual and the community. Just what does this obligation involve?

For the medical student during his university formation: the obligation of seriously applying himself to study that he may acquire the requisite theoretical knowledge as well as the practical ability necessary to apply it.

For the university professor: the duty of teaching and communicating to his students in the best possible way knowledge and its applications. He must never give a diploma certifying professional ability without being assured of this same ability beforehand by a thorough and conscientious examination. To act otherwise might involve serious moral fault because it might expose both private and public health to very grave dangers.

For the doctor in practice: the obligation of keeping abreast of developments and progress in medical science. To this end, he should read books and scientific journals, participate in conventions and academic courses, converse with his colleagues, and consult with professors of medicine. This obligation of striving constantly to better himself binds the doctor in practice insofar as it is reasonably possible for him to fulfill it and insofar as the good of his patients and the community require it. You should manifest a knowledge and professional ability that is second to none. Indeed, you should excel; for, in this way, you will convince others of the moral principles you hold.

### Conclusion

Luke, whom St. Paul called "our most dear physician" (Col. 4:14), wrote in his gospel: "And when the sun was setting, all who had persons sick with various diseases brought them to Him; and laying His hands on each of them He cured them" (Luke, 4:40-41). Although he does not possess such a miraculous gift, a Catholic doctor of the kind that his profession and the Christian way of life demand will be sought out as a refuge by the afflicted. They will seek care at his hands. God will bless his learning and skill that he may cure many. And, though he may fail in this at times, he will at least solace those in distress.

With the hope that God may grant you such gifts in abundance, with a full heart, We impart to all of you here, to your families, to your dear ones, and to the sick entrusted to your care Our paternal Apostolic Benediction.

# The Resident Surgeon and the Private Patient

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WHAT restrictions would moral theology impose upon the surgical activity of student doctors in residency training? Apparently the question is of more than ordinary concern to physicians at the present time, since in varying forms it has been asked with a remarkable frequency within the past year or so.

The problem, as I understand it, emerges from an accumulation of several facts, the first of which is the imperative need that hospitals, for the good of medicine and consequently for the common good, engage in educational programs. Secondly, it is beyond question that a sine qua non of any such program is the provision of actual surgical experience for resident surgeons. And, thirdly, it is alleged that the number of service patients in some hospitals is not sufficient to provide residents with the amount of surgical experience desirable in the ideal order. Hence I am convinced that what doctors really want to know when they ask questions such as this is whether it is morally permissible to make use of private patients in the training of surgical residents.

For the sake of clarity let me suggest two hypothetical cases:

1) While traveling, Mr. A is stricken with severe abdominal pain and nausea. Proceeding to the nearest hospital, he is examined by an intern whose diagnosis of appendicitis is confirmed by a staff physician. Mr. A authorizes the hospital to provide surgery, and the appendectomy is performed by a resident surgeon under the supervision of his chief.

2) Advised by his physician that an appendectomy is imperative, Mr. B engages Dr. X, a surgeon of considerable repute, to perform the operation. Dr. X is present in a supervisory capacity during the entire procedure, but allows Dr. Y, a senior resident with a brilliant record, to perform the appendectomy.

Concerning each of these cases the question is the same: is the resident surgeon justified in doing what he does? Or perhaps the question should be worded: is the qualified surgeon justified in allowing the resident to do what he does in each case?

## TWO RIGHTS OF THE PATIENT

In attempting to solve a problem such as this, the moralist would instinctively begin his thinking in terms of two fundamental rights of the surgical patient: (1) his innate right to be protected from all unnecessary surgical risk, and (2) his contractual right, if any, to be treated by the surgeon of his own choice.

Of these rights, the first is the

inviolable prerogative of any and all surgical patients, once they have been accepted as such either by an individual physician or by a hospital or clinic. The second, however, is properly reserved to the patient who de facto has engaged an individual surgeon for a particular operation — the so-called "private patient." The question of resident surgery will and must be solved according as these rights are respected or violated in particular cases.

### GREATER RISK?

From a practical and realistic point of view, it would be silly to contend that greater risk to the patient is necessarily involved in every concrete instance in which a resident, rather than a qualified surgeon, is allowed to operate. The resident surgeon cannot be written off as a rank amateur. He is a doctor of medicine with a certain amount of surgical experience behind him. It is true that the resident is less experienced than the qualified practicing surgeon — and presumably the less capable of the two if one compares the totality of their respective surgical abilities. But that difference in *total* experience and skill need not necessarily be a vital factor in a certain number of particular surgical procedures, especially at the level of what doctors would consider routine surgery. Except for a certain facility and confident familiarity with which the more experienced man would approach such a bit of surgery, his work in a particular instance might not differ substantially from that of a resident under proper supervision.

It would be a different matter, of course, with more complicated or more delicate operations where high skill and long experience really count. But no conscientious surgeon would think of deputing that type of operation to a relatively unskilled and inexperienced underling.

The point to be made here is this: there are surely many cases where a staff surgeon could honestly and prudently judge that a certain resident is quite capable of performing a particular type of surgery without additional risk to the patient. Presumably this is the only kind of operation which a reputable surgeon would allow a resident to perform. Granted, therefore, a careful selection of cases according to the resident's known ability — and granted, too, proper supervision throughout the course of the operation — it is entirely possible that the patient's right to be protected from unnecessary surgical risk can be adequately safeguarded even when a resident surgeon is allowed to operate.

### CONTRACTUAL RIGHTS OF PRIVATE PATIENTS

A considerably greater difficulty, however, is posed by the contractual right of the private patient to be treated by the surgeon of his own choosing.

By "private patient" I understand the individual who prior to surgery has explicitly engaged a specified surgeon to operate. That, I believe, is the generally accepted meaning of the term in contrast, for instance, to the service patient

for whom the hospital, as authorized agent, provides a surgeon of its choice. To what is the private patient in justice entitled by virtue of the contract he has made with an individual surgeon?

Let us suppose that such a patient should expressly stipulate — as reasonably he might — that no one but the surgeon himself perform the actual operation. Would not the physician, once committed to the case on this explicit understanding, be in conscience bound to observe that part of his contract? Now even though that stipulation may seldom be expressly stated, to me it seems obvious that implicitly uppermost in every private patient's intention when he chooses a surgeon is the desire to secure for himself all the surgical skill (manual skill included) of this particular doctor, and not that of any substitute. Such a patient, I am sure, goes to surgery confident that the surgeon he has engaged will actually perform the operation, at least in its substantial essence. And if that is the service which the patient wants and for which he is paying, that is the service he is entitled to receive. Ultimately it is the violation of this right of the private patient to receive treatment from the surgeon of his choice that constitutes the essential malice of ghost surgery.

I have heard it suggested that all the patient really wants his surgeon to provide is successful surgery, regardless of the hand that performs it, and that implicitly he is willing to allow a resident to operate under the surgeon's supervision if in the latter's judgment the resident is competent. This interpretation of intention might possibly be verified in a limited number of cases, but to my mind presumption is very strongly against it. It certainly would not be my own intention if I as a patient were to make a choice of surgeon. Nor do I think that doctors themselves would readily undergo surgery on that understanding. And I doubt very much that a surgeon who might defend that presumption would agree to put it to the test by openly informing a patient that a resident would perform, or had performed, the actual surgery even under supervision.

It has also been alleged that, because the surgeon accepts all medical and legal responsibility for a resident's surgery, he has in no way betrayed his patient's interests. That argument is simply irrelevant. It is not only the surgeon's acceptance of responsibility for which the patient has contracted, but also the surgeon's own operating skill. To deny him the latter is a breach of contract.

Hence whatever concession may be made in regard to a resident's ability to perform certain operations without adding notably to the patient's risk, it cannot be said that no real injustice is done the private patient if, without his knowledge and consent, a resident is allowed to take the surgeon's place at the operating table. In all probability doctors would agree that the likelihood of obtaining explicit consent from a private patient for such an arrangement is at best minimal. And if private patients in general would be aghast

at the open suggestion that a resident be allowed to perform the operation for which a qualified surgeon is being paid, there seems to be no justification for proceeding on the basis of presumed consent.

### RULING OF ACS

If in the opinion of some surgeons it savors of the ivory tower so to restrict the surgical training of residents, I can only refer them to the ruling of their American College of Surgeons. In December 1953, the Board of Regents of that College formulated definitions of several unethical practices, among them that of ghost surgery. Commenting on these definitions, Paul R. Hawley, M.D., wrote as follows:

> Their formulation was not accomplished without serious consideration of their impact upon wholly ethical requirements of surgical teaching and practice. The effect of the definition of ghost surgery upon resident training aroused the most concern; yet the Regents decided unanimously that honesty demanded that no exception be made in this respect. That good resident training can be provided within this limitation has been demonstrated.[1]

Five months later the Board revised its stand on the application of ghost surgery to residency training programs:

> The Board considers it to be a breach of ethics when any patient who has made an agreement with a surgeon is operated upon by another without knowledge and consent of the patient. However, the Board considers it proper for the responsible surgeon to delegate to his assistant the performance of any part of a given operation, provided the surgeon is an active participant throughout the essential part of the operation. *The Board of Regents approves the inclusion of all patients in residency training programs* (emphasis added).[2]

Finally one year later, as reported again by Dr. Hawley, the Board resumed its original position:

> On 7 December 1953, the Board of Regents of the American College of Surgeons adopted definitions . . . of four unethical practices. The Trustees of the American Medical Association concurred in these definitions.
>
> A number of protests were made against the strict application of the definition of "ghost surgery" in the training of residents in surgery and the surgical specialties. In an effort to reconcile this definition with the realities of resident training, the Regents issued on 1 May 1954, a supplementary statement . . .
>
> This latter effort, in turn, met with many objections from Fellows who wanted no compromise. The Board of Regents then turned for advice to a large and representative group of teachers of surgery. It was the consensus of this group that the original definition of "ghost surgery" is entirely applicable in resident training, and that no modification or explanation is necessary or desirable.
>
> At its meeting on 4 June 1955, the Board of Regents rescinded its statement of 1 May 1954, and reaffirmed its earlier definition of "ghost surgery," which is: "*Ghost surgery* is that surgery in which the patient is not informed of, or is misled as to, the identity of the operating surgeon."[3]

In fairness and in courtesy to those who formulated the above statements, it should be kept in mind that these pronouncements were made by doctors, who naturally enough speak the language of doctors and not that of theologians. If, theologically speaking, these statements leave something to be desired, it is certainly not in a spirit of condescension that these deficiencies are remarked here. I want only to emphasize the fact

[1] *Bulletin of the American College of Surgeons* 39 (Mar.-Apr., 1954) 72.

[2] *Ibid.* (July-Aug., 1954) 152.

[3] *Ibid.* 40 (Sept.-Oct., 1955) 302. This directive was most recently reaffirmed *ibid.* (Sept.-Oct., 1956) 429-30.

that, while I agree with the ultimate conclusion of ACS regarding the restriction imposed upon resident surgeons, I do so by reason of a compelling moral principle and not because the policy appeals to me as merely the more honorable or the more expedient of two legitimate choices.

For one might get the impression from these several pronouncements of ACS that its opposition to residents' operating on private patients is not a strict issue of moral right and wrong, but only a matter of the better policy — something that could be legitimately decided, for instance, by a majority of aye's or nay's. One might also conclude that if residency training in surgery should in the future require it, this restriction on resident surgery could licitly be rescinded. Neither conclusion can be admitted if one concedes that, by virtue of the patient-surgeon contract, only the surgeon has any right to operate on his private patient. "The physician has no other rights or power over the patient than those which the latter gives him explicitly or implicitly and tacitly"[4] — and that is the natural-law basis on which my own conclusion stands.

## SUMMARY

1) The lawfulness of permitting residents to operate on private patients will be determined by two natural rights which those patients possess: (a) the right to be spared all unnecessary surgical risk, and (b) the right to require of the contracting surgeon the total personal service which they reasonably expect.

2) The element of additional risk can be avoided if cases are carefully chosen according to a resident's recognized surgical ability, and if throughout the operation he remains under the supervision of a qualified surgeon. It should be conceded that surgical residents can be entirely competent operators in selected cases. Hence it is not necessarily inability which is invoked as the reason for denying them surgical rights with regard to private patients.

3) Consent of the private patient, however, to undergo surgery at the hands of anyone other than the contracting surgeon is a prime requisite for the lawfulness of this practice. Since it does not seem likely that this consent would ordinarily be given by the private patient for a resident actually to operate, presumption of that consent in ordinary circumstances does not seem to be justified.

## CONCLUSION

On the strength of these premises, my solution of our hypothetical cases would be as follows:

1) The resident surgeon is morally justified in performing the appendectomy. Mr. A has engaged no surgeon of his own, but has authorized the hospital to provide a competent operator. On the assumption that the resident surgeon is prudently judged to be competent, no moral objection can be raised to his operating under proper supervision.

[4]Pope Pius XII, *Allocution to First International Congress on the Histopathology of the Nervous System*, Sept., 1952. Cf. LINACRE QUARTERLY, Nov., 1952, p. 101.

2) Neither Dr. X nor Dr. Y nor the hospital can be justified in this case. The patient has contracted with Dr. X only, and cannot be presumed to consent to the substitution of the resident as operator, even under Dr. X's supervision.

While these two cases are more or less clear-cut, there are others which are not so easy of solution because they verge on the borderline. I refer to instances in which residents are allowed to *assist* at surgery performed on private patients. Certainly there is a considerable area within which no reasonable patient would object to a resident's lending the operating surgeon a helping hand. Everyone understands at least vaguely that surgery is not a one-man performance and that various assistants have to be on hand to relieve the surgeon of details extraneous to the actual operation. To know that another doctor, in the person of a resident, is standing by to help under the surgeon's direction would strike me as being more reassuring than disturbing to a reasonable patient, and something to which he would readily consent.

The difficulty here lies in determining satisfactorily the limits within which the resident can truly be said to be assisting at, and not actually performing, the operation. That is a question which the moralist must transmit to the surgeon — and perhaps even the surgeon can offer no more than a rough rule of thumb. One can, as did ACS, talk about "the essential part of an operation" (thereby implying parts which are less than essential), but what precisely that may mean in terms of a tonsillectomy, an appendectomy, a hysterectomy, etc., is not for theologians to define. But we would, I think, concede that if the surgeon himself performs what doctors generally would consider the substantial essence of an operation, he would be morally justified in supervising a competent resident's execution of other details.

—

THE EVANSVILLE, INDIANA, GUILD reports that Dr. Thomas A. Dooley of *Deliver Us From Evil* fame, now engaged in Operation Laos in Indo-China, has been accorded honorary membership in the group. In addition to visiting the Mead Johnson Co. plant in that city before leaving for his mission, he met with the Executive Committee of the Guild and also lectured to Evansville physicians, clergy, and others. In his book this young Navy doctor gives a first-hand account of finding himself suddenly ordered to Indo-China, just after the tragic fall of Dien Bien Phu. In a small international compound within the totally Communist-consumed North Viet Nam, he built huge refugee camps to care for the hundreds of thousands of escapees seeking passage to freedom. Through his own ingenuity and that of his shipmates, he managed to feed, clothe, and treat these leftovers of an eight year war. Dr. Dooley "processed" more than 600,000 refugees down river and out to sea on small craft, where they were transferred to U. S. Navy ships to be carried to the free areas of Saigon. Not satisfied with past labors, Dr. Dooley has returned to Saigon, Viet Nam to give further assistance. The Mead Johnson Co. has provided him with vitamins and other products to use on his Operation Laos.

# *Benefactor of Mankind .....*

## Louis Pasteur

SECOND in the series of biographical sketches of the Catholic men of science honored by The Federation of Catholic Physicians' Guilds in the permanent display set up for convention use, THE LINACRE QUARTERLY introduces Louis Pasteur, one of the greatest figures in bacteriological learning. He was born at Dôle in France, December 27, 1822, the son of a tanner. Unlike his distinguished compeer, Koch, who began as an obscure country doctor, he was early educated in chemistry and achieved distinction in other lines of research before turning his attention to the study of bacteria, in which field his name is resplendent. In 1847 he was graduated from the École Normale, in Paris, and in the following year became professor of physics at Dijon, shortly resigning this post to become professor of chemistry at Strassburg. He had already made important discoveries in chemistry and was at this time absorbed in his studies as to the nature, causes, and effects of fermentation, particularly in relation to the "diseases" of beer and wine, a problem which had long engaged the attention of chemists. He was always an indefatigable worker and after long and thorough experimenting, he proved fermentation to be due to the presence and growth of tiny organisms, or ferments, and set himself to find a way by which the formation of these organisms might be prevented.

In 1854 he left Strassburg for Lille; three years later he held the important position of director of the École Normale Supérieure. Here he continued his work, undiscouraged by the opposition of friends who believed that he was carrying on a fruitless quest, and eventually he was rewarded by finding it within his power to give to the world specific knowledge which has proved of incalculable benefit to mankind. One of the first practical results from his study of fermentation was to revolutionize the industry of beer and wine manufacture, making it possible to abandon the old uncertain methods and carry on the work with assurance of definite results.

In 1865 (at that time, professor of chemistry at the École des Beaux Arts) his help was sought in investigating a silkworm disease which was making severe ravages and ruining the silk industry in the south of France. Although he had never seen a silkworm, he attacked the problem, at the insistence of his friend Dumas, and within a few months was able to discover the origin of the disease and suggest means for its cure. He also developed a method of inoculation of cattle to prevent the dreaded

anthrax which took such heavy toll and occasioned severe financial loss to cattle raisers all over the world.

His greatest gift to mankind, however, and the one which is inseparably linked with his name in the popular mind is his treatment for hydrophobia, which was developed after long and patient experiments in inoculating dogs with a virus from the spine of a rabid animal. The treatment having proved successful with dogs, he tried it with human beings in 1885, meeting with equal success. Three years later the Pasteur Institute was founded in Paris. Among early contributors was one, young Joseph Meister, who was the first human being to be treated by Pasteur for hydrophobia, after having been gashed fourteen times by a mad dog. Many thousands of lives have been saved through the Pasteur treatment; by 1912 more than 30,000 cases of hydrophobia had been treated, with a death rate of less than one per cent.

It may be said that, far from taking only an academic or scientific satisfaction in the results he was able to achieve, Pasteur's gratification was always immensely increased when his discoveries were put to some immediate practical use. Certainly in this respect he had repeated rewards, as in the case of the beer and wine industry, the difficulty of the silk growers and, greatest of all, in the saving of human life through his hydrophobia treatment.

On his seventieth birthday, plans were made for a celebration. Delegations of scientists gathered in Paris from many nations to do him honor. In the hall at the Sorbonne a triumphal march was played and at his entrance the entire audience rose to greet him with applause. In this hour it was given Louis Pasteur to see how much human life owed him and will owe him in the years to come. His speech was read by his son. In addressing the students, who were there in large numbers, he said: "Young men . . . live in the serene peace of laboratories and libraries. Say to yourselves, first of all, 'What have I done for my instructors?' And as you go on further, 'What have I done for my country?' . . . until the time comes when you may have the happiness of thinking that you have contributed in some way to the progress and to the welfare of humanity."

Pasteur's faith was as genuine as his science. In his panegyric of Littré whose *fauteuil* he took, he said: "Happy the man who bears within him a divinity, an idea of beauty and obeys it; an ideal of art, an ideal of science, an ideal of country, an ideal of the virtues of the Gospel." These words are graven above his tomb in the Institute Pasteur. He further states, "These are the living springs of great thoughts and great actions. Everything grows clear in the reflections from the Infinite." Some letters to his children bespeak profound, simple piety. He declared, "The more I know, the more nearly is my faith that of the Breton peasant. Could I but know all, I would have the faith of a Breton

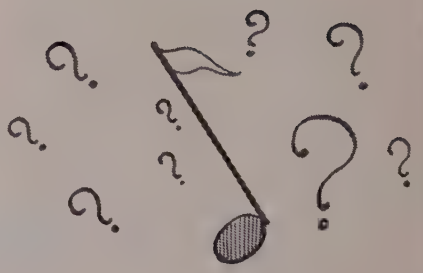
peasant woman." What he could not above all understand is the failure of scientists to recognize the demonstration of the existence of the Creator that there is in the world around us. During his early years at Strassburg he had married one Mlle. Laurent, who was a devoted wife, and we may believe that her life with this simple, affectionate and great-hearted man was a singularly happy one. He died at St. Cloud on Sept. 28, 1895 at the age of seventy-three.

WORD HAS COME FROM THE BROOKLYN CATHOLIC PHYSICIANS' GUILD OF THE DEATH OF DR. RICHARD A. RENDICH, K.S.G. SERVING FOR A TIME AS PRESIDENT OF THIS GROUP, DR. RENDICH WILL ALSO BE REMEMBERED AS ONE OF THE FOUNDERS OF THE FEDERATION OF CATHOLIC PHYSICIANS' GUILDS. A GREAT INTEREST OF HIS WAS THE FAMILY COMMUNION CRUSADE WHICH MOVEMENT HE INITIATED SOME SIX YEARS AGO. HE SERVED AS CHIEF ROENTGENOLOGIST OF THE NEW YORK CITY DEPARTMENT OF HOSPITALS FROM 1919 UNTIL HIS RETIREMENT IN 1950.

TO MRS. CLAIRE RENDICH, HIS WIFE, AND BROTHERS AND SISTERS THE FEDERATION OF CATHOLIC PHYSICIANS' GUILDS EXTENDS SINCERE SYMPATHY.

# *Medical Melody*

It is not known whether the Muse of music, Euterpe, is a blood relation of Aesculapius, the god of medicine, but we suspect that some relationship exists — however tenuous. As evidence for this hypothesis, we offer the following musical compositions and an appropriate (?) medical connotation:



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|---|---|
| The Sorcerer's Apprentice (Dukas) | The Medical Student |
| Rounds (Diamond) | Ward Walks |
| Wasps (Vaughan) | Antihistamine Therapy |
| Ionisation (Varese) | Electrolyte Therapy |
| The Slippers (Tchaikovsky) | Intervertebral Disks |
| Undertow (Schumann) | Trichophytosis |
| Mass of Life (Delius) | Autopsy |
| John Brown's Body (Bishop) | Tissue Culture |
| Surprise Symphony (Haydn) | Clinicopathological Conference |
| Academic Festival Overture (Brahms) | Graduation |
| Trial by Jury (Gilbert and Sullivan) | Practice |
| Hunt Symphony (Haydn) | Consultation |
| In the Beginning (Copland) | Obstetrics |
| Mother Goose Suite (Ravel) | Pediatrics |
| Enigma Variations (Elgar) | Internal Medicine |
| The Lost Chord (Sullivan) | Laryngology |
| Night on Bald Mountain (Moussorgsky) | Dermatology |
| Sleeping Beauty Ballet (Tchiakovsky) | Anesthesiology |
| Fantastic Symphony (Berlioz) | Psychiatry |
| Fancy Free (Bernstein) | Psychoanalysis |
| Nutcracker Suite (Tchiakovsky) | Neurosurgery |
| Pomp and Circumstance (Elgar) | Some Other Man's Specialty |
| Yeoman of the Guard (Gilbert and Sullivan) | Nursing Staff |

Kind permission was given to reprint the above which appeared in the September 1956 issue of ***Physician's Bulletin*** published by Eli Lilly and Co., Indianapolis, Indiana.

IMPORTANT
PUBLICATION

# *Beginning Your Marriage*

John L. Thomas, S.J.

**Review by**

Rev. John J. Egan

The Cana Conference of Chicago

Sometimes good things do come in small packages. After having made one's way through many large and frequently loosely written works that present partial views as complete guides to marriage, it is gratifying to find a relatively thorough, well-balanced and realistic work in a pamphlet of seven chapters and 104 pages.

*Beginning Your Marriage* is a small booklet that has been published by the Cana Conference of Chicago to fill the need for a brief text for engaged couples on the questions about the final days of courtship and the initial days of wedded life. Intended for engaged couples, it presupposes the decision for marriage and is not concerned with such preliminary questions as basic sex instructions, dating or courtship problems.

The author is the Reverend John L. Thomas, S.J., assistant director of the Institute of Social Order at St. Louis University. His deep interest in the problems of the modern marriage and the family is evident from his other works, as *The American Catholic Family* (Prentice-Hall, 1956) and a *Guide to Catholic Marriage* (Bruce, 1955) on which he collaborated with Clement Mihanovich and Brother Gerald Schnepp, S.M. His qualifications are those of a priest and professional sociologist writing in an area of his field in which he has specialized. It is only natural that the preoccupations and viewpoints of the sociologist rather than those, *e.g.*, of the psychologist, economist, or physician, should be apparent throughout the work.

The booklet is of peculiar value because of the broad but detailed presentation of a Catholic philosophy that the author has been able to inject in his terse treatment of the various practical problems that

a newly wedded couple will meet. Indeed, the matter treated is so broad and the problems considered are so numerous and varied that the booklet seems like a careful condensation of a much larger work. Nonetheless, readability of style (despite the scattered appearance of technical theological and sociological terms) and humor of approach have not been sacrificed.

Some idea of the wealth of ideas presented can be found in a list of the subjects treated. The first chapter quite adequately outlines the theology of human life and the role that the division of the sexes and marriage play in this synthesis. The second chapter sketches in the personal, social, religious, and properly sacramental aspects of marriage. In the third chapter the social elements are discussed under the headings of ecclesiastical law, state law, and current marital customs. Under the consideration of the various adjustments that must be made, the author in the fourth chapter takes up the personal aspect of marriage — adjustments in sexual, spiritual, and economic matters; adjustments with the other's family and friends; adjustments with the realities of family living. The marriage act forms the subject of the fifth chapter; here the author is not concerned so much with the techniques as he is with the personal significance and values necessary to make physical love a genuine expression of Christian married love. In the sixth chapter various specific sexual problems and questions common to newlyweds are handled briefly but adequately. The seventh and final chapter closes the booklet with a discussion of the couple's vocation and task of living, work, and saving their souls together.

This little volume can serve as an excellent pre-marital instruction text. It is, perhaps of a specific use to physicians in the guidance of young people about to be married, or recently married, for it provides an excellent integration of the physical aspects of marriage with the psychological and spiritual factors which make them meaningful. It is too brief to serve as a text for any marriage course in school. Its frank discussion of sexual love likewise precludes its use to all but mature persons who are soon to be married. Within these limits, however, it not only is the one booklet of its kind, but probably will remain among the best for some years to come.

*Beginning Your Marriage*

Booklet published by
Delaney Publications
206 So. Grove Avenue
Oak Park, Illinois

50c a copy, plus postage
20% discount on quantity orders of 10 copies or more

# The Linacre Quarterly

JOURNAL OF THE FEDERATION
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May we suggest that you remember someone with a subscription to LINACRE QUARTERLY as a Christmas gift?

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A remembrance that repeats itself throughout the year . . .